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Accountable Care NEWS

Accountable Care Organizations:
Accountable to Whom? And To What?

By Jay J. Cohen, M.D., MBA, President/Chairman of the Board, Monarch Healthcare

When invited to write this article about the future of Accountable Care Organizations (ACOs), I found myself focusing foremost on the philosophical underpinnings that will drive them. In recent months, thousands of organizations throughout the country, including mine, Monarch HealthCare, a Medical Group, Inc. (Monarch), are claiming to be ACOs. Yet unequivocally no one truly knows what constitutes a successful ACO. So on what basis are these claims to the ACO designation being made?

Each of these organizations has its own rationale as to why it qualifies as an ACO. Among Monarch's justifications is inclusion in the ACO pilot project orchestrated by the originators of the ACO concept, the Engelberg Center for Health Care Reform at Brookings and The Dartmouth Institute for Health Policy and Clinical Practice. But it is not enough to call oneself an ACO – ultimately, what will be most important is the ability to demonstrate fulfillment of the "ACO promise". Which organizations will deliver on this promise boils down to how they answer three fundamental questions: To whom are you accountable? For what are you accountable? And what approaches are you taking to accomplish these goals?

Thirty years of experience within the "California model" of coordinated care medical groups has influenced my views regarding ACOs and which business models are most likely to succeed.

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In This Issue

Building the Foundation:
A Framework and Process for Initiating Cultural Transformation of an Accountable Care Organization

By Jeff Hannah, ABD, M.A., Peter W. Roberts, M.H.A., M.H.E., and James M. Levett, M.D., FACS

As the healthcare industry continues to respond to market and legislative pressures to enhance the quality of care and reduce costs, the Accountable Care Organization (ACO) is receiving greater scrutiny from government, providers and the media. While quality and cost goals may, at times, seem mutually exclusive, the ACO presents a promising model for integrating delivery system reform with payment reform.

Numerous articles have highlighted the varied forms, structures and outcomes of ACOs.[1] Only recently has attention turned to the function of change management when establishing an ACO. Levett, Hannah & Roberts[2] maintain that cultural transformation is integral to the development of the ACO and identify four phases of culture change: (1) Exploration; (2) Planning; (3) Execution; and (4) Sustaining.

The authors illuminate the roles and responsibilities important to each phase -- as well as transitional steps between each -- and propose that the Execution and Sustaining phases must eventually become an on-going and self-perpetuating cycle (Figure 1). The article emphasizes that effective cultural transformation requires specific roles to emerge and key behaviors and activities to occur at appropriate junctures.

In this current article, the authors expand on the 4-phase model to provide a framework and process for implementing the first phase of the cultural transformation (Exploration) and laying the foundation of an accountable care organization

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Editor's Corner

Pierce Conran, Editor, *Accountable Care News*

We received the following comments regarding the place for electronic health records (EHRs) in accountable care: Readers of *Accountable Care News* are invited to submit questions or thoughts to editor@accountablecarenews.com.

Dear Accountable Care News,

How can accountable care be delivered without a correct model for healthcare and without an appropriate electronic health record (EHR) system? Chronic illness care, for example, is the source of 70% to 80% of U.S. health care costs. Among the chronic illnesses, diabetes has priority.

A correct model for the 21st century would take into account the mass of clinical literature on diabetes and periodontal disease. Medicare, for example, which offers no dental care, is a seriously flawed model. At the beginning of the 21st century an IOM report included this wording regarding "medically necessary" about dental care in Medicare: "Such a restrictive definition may suggest that periodontal or other tooth-related infections are somehow different from infections elsewhere and imply that the mouth can be isolated from the rest of the body, notions neither scientifically based nor constructive for individual or public health." in Extending Medicare Coverage for Preventive and Other Services by Marilyn J. Field, Robert L. Lawrence, and Lee Zwanziger, Editors; Committee on Medicare Coverage Extensions, Division of Health Care Services, IOM, 2000.

This was also the year of: Oral health in America: a report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. A decade later, any health care model which does not integrate medical and dental care sacrifice quality of care and patient safety (also accountability).

Any EHR product which does not integrate medical and dental records is obsolescent. Examples of modern EHR technologies exist (in Federal health care agencies such as the Veterans Affairs Department (VistA), the Indian Health Service (RPMS), and the U.S. Military (AHLTA), and, outside of Federal care, in the Marshfield Clinic system in Wisconsin.

See: http://www.marshfieldclinic.org/patients/?page=nytimes_122908 regarding "Electronic Medical Records Cited" and saying: "To visit the Marshfield Clinic, a longtime innovator in health information technology, is to glimpse medicine's digital future. Across the national spectrum of health care politics there is broad agreement that moving patient records into the computer age, the way Marshfield and some other health systems have already done, is essential to improving care and curbing costs." 21st century EHR technology must support multi-domain communication among medical and dental providers.

Please see: Powell VJH and Din FM, "The Medical-Dental Home: Achieving Comprehensive Care for Chronic Illness through Integrating Medical-Dental Care and Data," Medical Home News 1, 3 (May, 2009): 1, 5-7. See: http://www.connected-health.org/media/224380/mhnnews0509.pdf Also, please see our list of contact points between medical and dental care.

What are you doing for the sake of accountability in this sense?

Sincerely,

Valerie J H Powell RT(R) PhD
University Professor, Computer & Information Systems Project on Clinical Data Integration (CDI) Robert Morris University

Accountable Care Organizations…. *continued*

Physicians throughout California have successfully organized and collaborated for decades as Independent Practice Associations (IPAs) and integrated medical groups designed to deliver high-quality cost-effective care. This statewide phenomenon has been catalyzed by the robust presence of Permanente Medical Group as a formidable competitor and the state's legislative prohibition on corporate practice of medicine. Most of these groups, including Permanente, share best practices as members of the California Association of Physician Groups (CAPG), recognized recently as "the largest U.S. accountable care [trade] association".[1]

Physicians organizing into groups to deliver accountable care are not singularly a California phenomenon. There are national organizations, i.e. Council of Accountable Physician Practices (CAPP) and Physician Groups for Coordinated Care (PGCC), which represent a host of medical groups and IPAs across the country that for decades have been taking accountability for the care they provide. These models exist primarily in regions where enrollment in Medicare Advantage and/or commercial managed care programs is high. Pre-payment (capitation) compensation methodologies provide the cash flow these organizations need to support the administrative infrastructure required to deliver high-quality cost-effective care.

As our nation progresses more globally toward accountable care, multiple business models will be tested. In many parts of the country physicians remain disaggregated. Where this market dynamic exists, hospital-centric models may be the predominant ACO paradigm. In other geographies, independent physicians are coming together in "virtual groups" to assume accountability for the care they provide collectively. The need exists to experiment with a variety of business models to meet the needs of patients in diverse markets; however, concern is warranted regarding the ability of some of these models to succeed. Will the model construct matter in determining an ACO's success? To answer this, I'll highlight some elements that differentiate existing physician led (governed) ACOs from other models being considered. The value system upon which an ACO is based is important and physician led organizations have a number of distinct advantages. First, doctors in general are an altruistic lot. Although there are some well-documented examples of physicians who have strayed from their altruistic natures, on the whole their adherence to this core value is strong and laudable.

Second, physicians possess firsthand experience caring for people over extended periods of time across the entire continuum of care. They are the primary accountable parties when their patients become infirmed. It is an awesome responsibility to treat someone at risk of dying prematurely or to tell someone their parent has just passed away. Experiences such as these deeply affect the way one views the "business of medicine". This perspective is always important, but is most critical when dealing with thorny issues, e.g. when the interests of one's institution are in direct conflict with one's personal commitment to serving the greater good. A few years ago, a JAMA article regarding how effectively doctors comply with evidence based guidelines concluded that Medicare fee-for-service (FFS) patients received the recommended screening test (cardiac stress test) less than 45 % of the time prior to receiving the more invasive, risky, and costly alternative (elective PCI).[2] Importantly, Medicare FFS patients and the physicians caring for them generally do not have the support of ACO-like organizations with value systems that inspire care quality improvement and efficiency.

I was confident that physicians that embody an organization with just such a foundation perform better than their peers. Analysis of the data related to Monarch's 30,000 Medicare Advantage beneficiaries, utilizing the same criteria and methodologies used by the JAMA researchers, confirmed Monarch's patients received the evidence-based screening test over 90 % of the time prior to receiving the more costly invasive procedure. These results validated my premise: when provided with the correct philosophical and informational support, physicians will do the right thing for their patients more often. I believe the converse risk exists: ACOs formed by organizations reliant upon higher volumes and/or higher intensities of services will not be motivated to provide their physicians with the support described above, because of the adverse impact it would have on their revenue.

In conclusion, the ultimate success of an ACO will be based upon the vision and values that constitute its underpinning. Some ACOs being created today will succeed and others will fail. How an ACO fares will be determined by why its participants form it. There will be executives and providers who envision an ACO as their next high-margin revenue model, or a new way to increase negotiating leverage or control more of the health care dollar. These ACOs will not be capable of fulfilling the ACO promise and thus will fail. On the other hand, providers and executives who understand to whom and for what they are accountable will design high-quality cost-efficient models for the communities they have committed to serve, and they will be rewarded accordingly for the value they render. The Patient Protection and Accountable Care Act (PPACA) stipulates that an ACO must exceed quality thresholds in order to qualify for a shared savings bonus. Only models capable of successfully surmounting both of these challenges will withstand the test of time. Most likely, as a reader of this article, you work in the healthcare industry. Current circumstances are providing us with the opportunity to embody the altruistic spirit residing within our hearts. The fact remains that far too many of our patients, who are our customers, deserve better outcomes and experiences than we've provided in the past. Only we as an industry can rectify that. And for the sake of our nation and that of our future generations, we must learn to deliver the better outcomes and experiences our patients deserve more cost effectively too. In my view, ACOs whose vision and values impel high-quality cost-effective care are among our best hopes to achieve these goals.

[1] "Show Me ObamaCare," The Wall Street Journal, August 5, 2010.

2 Lin, G. A., Dudley, R. A., Lucas, F. L., Malenka, D. J., Vittinghoff, E., Redberg, R. F., "Frequency of Stress Testing to Document Ischemia Prior to Elective Percutaneous Coronary Intervention," JAMA Vol. 300, No.15 (October 15, 2008): 1765 – 1773.

Patient-Centered Team Care for Improved Management of Chronic Diseases

By Richard Dryer, MD, Kimberly Baker-Genaw, MD, and William Keimig, MD
Department of Medicine, Henry Ford Medical Group, Henry Ford Health System, Detroit, MI

The implementation of a functioning Medical Home can play a key role in the development of ACOs.

The Medical Home model for primary care, endorsed by national medical associations for Internal Medicine and Family Medicine [1-4], focuses on engaging the patient with a team of health care professionals to improve healthy behaviors and health outcomes. At our large health system in southeast Michigan, primary care physicians at 26 medical centers have been awarded the Blue Cross Blue Shield of Michigan (BCBSM) patient-centered medical home designation since inception by BCBSM in 2009. The annual designation awards physicians and outpatient clinics for implementing team care to manage a patient's health through various processes, such as convenient appointment scheduling, extended office hours, test tracking, e-prescribing, and an electronic health record to upkeep the patient's medical history.

While our 26 medical centers offer medical homes for primary care patients, an advanced model with special emphasis on team care of patients with chronic diseases has been developed and implemented at three sites. Designed by the Henry Ford Medical Group's Division of General Internal Medicine in 2007, this advanced medical home model required clinical practice redesign to change the traditional patient-physician focus of care to team-focused care. During the practice redesign process we invited patients to serve as advisors on our multidisciplinary planning team. Our patient advisors found the medical home term confusing and thus selected our program name "Patient-Centered Team Care" (PCTC). Patient advisors have offered critical feedback to our PCTC clinic processes over the past few years, and remain part of our planning team as we continue to refine the process and roll out additional PCTC clinics.

How Patient-Centered Team Care Works

The Team: Each PCTC clinic has on site the primary care physician, nurse practitioner, nurse case manager, clinical pharmacist, certified diabetes educator, dietician, medical assistant, and clinic service representative. A patient's team is led by the physician who decides which health care experts are required by the patient's condition and diseases. The team for a patient with diabetes, for example, may include the diabetes educator and dietician whereas the team for a patient with hypertension may include the dietician and clinical pharmacist. The patient may see or communicate with the nurse practitioner and/or nurse case manager in between visits with the physician, and also may see other team members during or in-between physician visits. Individualized, personalized team care to meet the medical needs of the patient remains the focus.

The Plan of Care: At the first PCTC clinic visit, the physician and patient together discuss and complete the patient's Plan of Care. The Plan of Care form documents the patient's current medical condition and chronic diseases as well as the patient's personal health goals (such as to quit smoking), lifestyle health goals (such as to increase exercise), medical health goals (such as to reduce cholesterol), and next steps for care (such as blood tests and a visit with the nurse practitioner). In this way the patient becomes engaged in self-management of healthy behaviors while receiving coordinated team care focused on disease prevention and disease management. Copies of the completed Plan of Care form are given to the patient to take home, retained in clinic for referral follow-up, and become a part of the patient's electronic medical record.

Education: Patients with chronic conditions are encouraged to attend patient education workshops focused on self-management of disease. These group classes require approximately 2.5 hours/week for six weeks. Other types of education classes such as smoking cessation and weight management are available as well.

Telemonitoring Tools: For patients with heart failure, we use a telemonitoring tool (Tel-Assurance, Pharos Innovations, Inc., Northfield, IL) to monitor symptoms in-between clinic visits. Patients call a toll-free number daily to answer several clinically validated questions about their medical status and to listen to a customized, 90-second educational message to reinforce education, diet, exercise, and compliance. Patients' clinical status information is available instantaneously via a secure online database for review by PCTC case managers. Based on these data, case managers may call patients at home to discuss symptoms and self-management steps, to titrate medication dosages for those patients requiring medication adjustments, as well as to arrange same-day or next-day clinic appointments for patients requiring prompt medical attention.

Measuring Health Outcomes

Various measures are being tracked to determine the short- and long-term outcomes of patient-centered team care. Since implementation of PCTC clinics in 2008, short-term results have shown a trend toward decreased emergency room visits and reduced hospital admissions for this group of patients. In addition, hemoglobin A1c values have improved for diabetic patients enrolled in PCTC case management for at least 90 days. These early outcomes give physicians the professional satisfaction that comes with knowing patients are receiving the close attention they need. PCTC physicians who didn't work regularly with case managers and nurse practitioners before practice redesign now report they do not want to work without these valuable health professionals.

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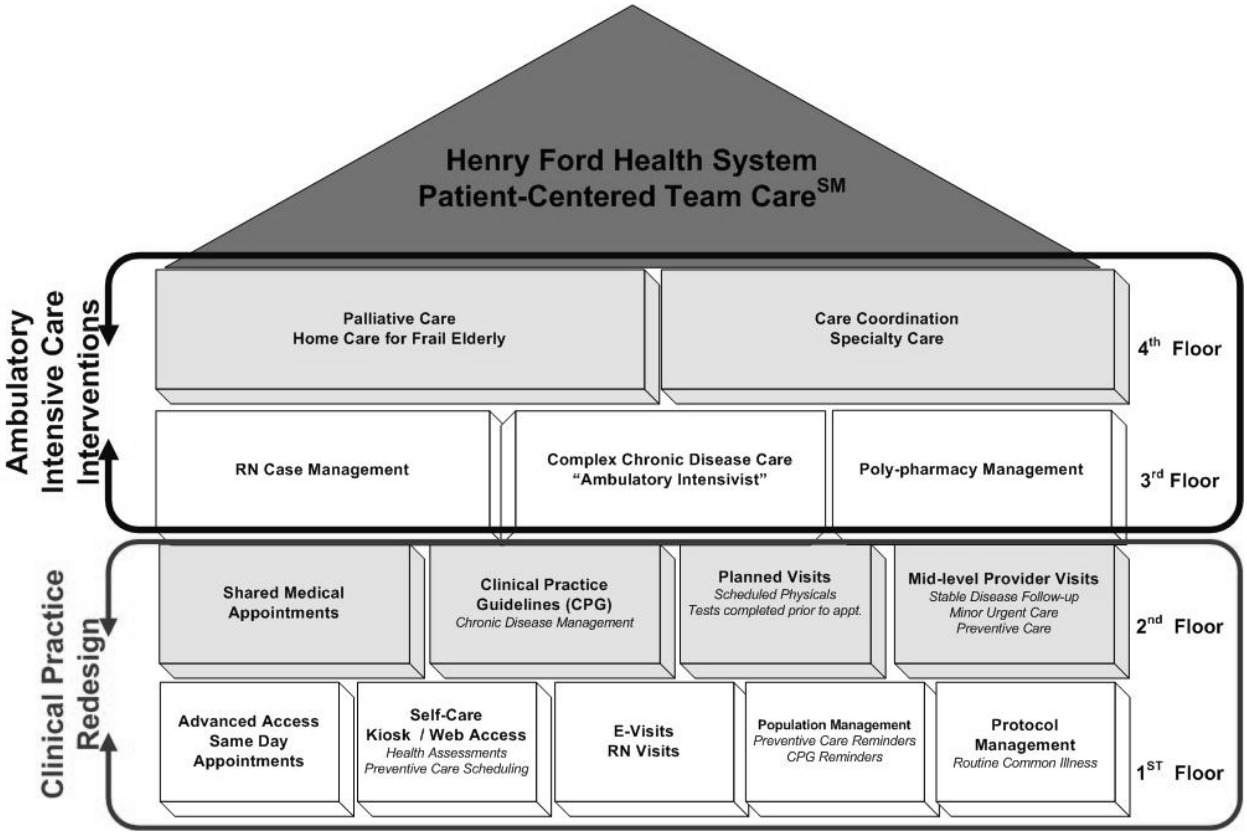
Patient Centered Team Care…. *continued*



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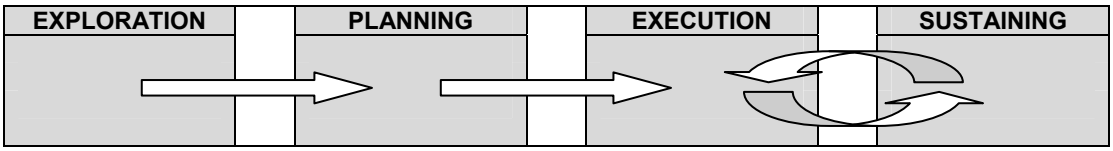


Figure 1. Cultural Transformation Phases and Intermediate Steps

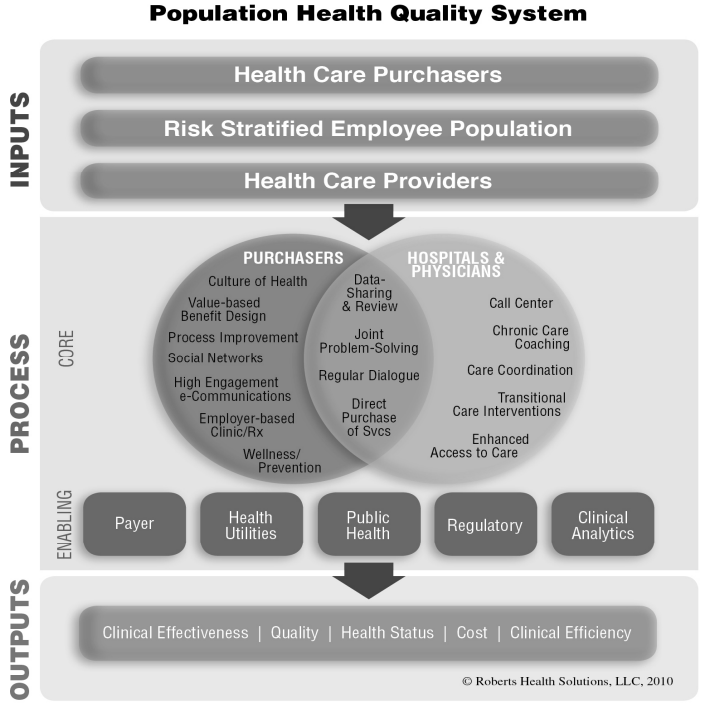
While all four phases have critical facets and accountabilities, the initial Exploration stage is foundational, to ensure that the transformational journey begins on solid footing. The Exploration phase is executed in three components: (1) administration of a readiness assessment of internal organizational capabilities and external resources in the local community; (2) identification of the provider network that will deliver a full range of clinical services, potentially including partner physician practices, facilities and medical groups; and (3) clarification of key leadership roles, structures and processes among the various parties. Realistically, the first two components occur simultaneously, but both must be completed prior to undertaking the third.

The driving force behind the ACO formation may come from the medical delivery system, a health plan or an employer. Although a single group or entity may provide early impetus, the success of this primary phase relies on the active engagement of all involved partner-collaborators in the community. Several authors have emphasized the importance of a community-based approach for creating a comprehensive and sustainable ACO system.[3] Specifically, each of the following must be completed in the Exploration phase of the cultural transformation:

- Self-assessment of the internal capabilities of each ACO partner -- e.g., existing systems and processes, opportunities for revenues and/or cost savings, and tolerance for risk – to target opportunities for improved population outcomes.
- Assessment of external capabilities – e.g., healthcare resources and levels of patient engagement in the targeted community -- to target opportunities for improved population outcomes.
- Quantification of the magnitude of improvement for targeted clinical areas.
- Agreement among the partner physician practices, organizations and agencies on a common vision and sense of urgency for change.
- Shared understanding among partner-collaborators of potential roadblocks and risks to ACO formation.
- Agreement on governance of the ACO.
- Initiation of dialogue to build a work plan for the ACO, including establishing legal, financial and management structures.

In order to complete an effective Exploration Phase, it is important to have a framework with which to appraise the service mix, potential collaborators and ACO capabilities. One simple, community-based framework is represented below in Figure 2.

Figure 2. Population Health Quality System: A Framework



Framework

The Population Health Quality System framework focuses specifically on population health management and articulates the Inputs, Processes, and Outputs in successful accountable care systems. The targeted employee population, providers, employers and health care purchasers in the community provide Inputs to the system – notably, these Inputs are influenced by a number of factors, including medical and non-medical health resources in the community, the employer work place, personal health resources available, social networks and even the media.[4] Inputs then fuel Core and Enabling Processes. In the figure above, Core Processes such as such as data- and information-sharing are the critical interfaces between the providers and the employer.

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Building the Foundation …. *continued*

It is important that Enabling Processes align with and support the Core Processes: to ensure a high level of coordination, a greater impact on the individual's behaviors, and desired outcomes for the population (measured as Outputs).

As illustrated in Figure 2, the first step in the Exploration Phase corresponds to assessment of internal and external Inputs, to quantify opportunities for improvement in the defined population. Internal opportunities for improvement may include potentially avoidable admissions/readmissions, emergency room visits, C-section rates and medication prescribing patterns. The external assessment in the Exploration stage examines specific clinical risks in the population as well as savings that can be accrued in each clinical area; the accessibility of community-based service providers and wellness programs, patient population demographics, and regulatory environment should also be evaluated.

The second component of the Exploration phase is identification of the potential ACO partners. Viable partner-collaborators – clinical practices, groups and agencies that either provide an essential segment of an integrated delivery system or offer a vital connection to the patient population -- will emerge from a thorough analysis of external resources. Other critical determinants include the capacity for information exchange with other partners, the ease of connecting data systems, and cultural compatibility.

Prior to making a commitment to participate, each entity should conduct an internal capability assessment, a comprehensive analysis of its own capacities and capabilities. For a delivery system, the assessment must incorporate a review of the current state of the primary care and specialty care networks, existing clinical and financial data systems, and cost variations that may result in revenue opportunities with the ACO. Additionally, it will be useful to scrutinize the delivery system's ability to assume financial risk and its experience implementing significant culture change.

For an employer, the internal capability assessment should entail, among other aspects, analysis of the care utilization patterns of its employees, the organization's ability to adopt new health benefit designs, alternative payment models for providers, and past experiences implementing substantive change with the employee population.

The third component of the Exploration phase involves clarification of crucial roles, structures and processes, best accomplished through formalized discussions with partner-collaborators. Multiple meetings will likely be necessary to reveal mutual interests in forming the ACO, confront potential roadblocks and limitations and risks, and finalize the ACO collaborative. A number of prepared discussion items can guide comprehensive review of fundamental issues (Table 1).

Table 1. Selected Discussion Questions for Exploration Meetings

What are the most compelling reasons to form an ACO, including the goals the stakeholders wish to achieve? From a clinical perspective, where is the most logical, opportunistic place to start?

- What about this community makes it necessary and urgent to form an ACO? What about this community would make it difficult to successfully implement an ACO?
- For each partner-collaborator, what are the rewards and benefits of participating in an ACO?
- What risks accompany formation of an ACO? In what ways can these risks be reduced to tolerable levels?
- For each partner-collaborator, what will present the greatest challenge(s) to participating – e.g., systems, staffing, clinical processes, financials, relationships with other partners?
- What kind of organizational culture do we want to create?

It is imperative that discussions not only create an urgency to form the ACO, but also build trust among participants. The research of John Kotter, widely considered the preeminent expert on change management, has consistently indicated that the first and most important step of organizational change is creating a sense of exigency.[5] According to Kotter, many change initiatives fail to meet expectations – or fail outright – because leaders do not present a urgent, compelling case for the change. In the Exploration meetings, several strategies can help to create a "burning platform" for change:

- Avoid long time periods between meetings, to encourage an aggressive approach and avoid drawing out the process
- Dedicate time to review the cultural transformation process, including roles and responsibilities
- At the end of each meeting, agree on the information that will be shared outside of the meeting – What/How to communicate with whom?

It is also necessary in the Exploration stage to foster a climate of trust among the ACO partner-collaborators. Trust is a function of effective communication, but can only develop organically and naturally. Meeting time should be dedicated to establishing guidelines for the group's communication and interactions, and from the outset, the champion and early leaders can set a tone of sincerity, objectivity, and frankness. The use of a skilled meeting facilitator can also help to stimulate open discussion and honest appraisal of issues.

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*T*hought Leader's *C*orner

Each month, *Accountable Care News* asks a panel of industry experts to discuss a topic of interest to the medical home community. To suggest a topic, send it to us at info@accountablecarenews.com.

Q. "Can Accountable Care Organizations have a meaningful impact on the cost-curve?

Most people are familiar with the saying that, "a bird in the hand is worth two in the bush." But who would accept the logic that, "a bird in the bush is worth two in the hand"? This is not a strategy that many providers will adopt but yet that is the logic that drives the shared savings concept for ACO reimbursement. A provider that is paid for billable services is going to be hard pressed to see the wisdom in reducing his/her encounters or his/her procedures in order to reduce the overall cost of care. That means a reduction in real earnings today for the prospect that a sufficient number of his/her colleagues also reduce their billings such that three years from now, if savings have been achieved, he/she will get his/her percentage of half the savings realized. A tough sell made even tougher when you add in the administrative overhead that has to be maintained to even qualify as an ACO. If ACOs are to be successful, then some form of capitation is going to have to drive the payment model. This allows for strategic management with a predictable revenue stream and something the ACO can rally around. California groups already fit that description and are better positioned than most of the rest of the nation to take on this challenge.

Keith Wilson, M.D.
Region 6 Medical Director, HealthCare Partners
Former President & CEO, Talbert Medical Group
Costa Mesa, CA

"It is the responsibility of healthcare systems to create accountability for the overall quality, cost and satisfaction of care in their communities. ACO's will unite hospitals, doctors, nurses and community resources to radically shift the way America delivers, pays for and even thinks about healthcare. Right now, up to 30 percent of the total funds spent on healthcare are wasted dollars. Within an ACO format, care will be more complete and coordinated with all care providers working together. One of the main goals is to avoid situations that waste time or money, such as unnecessary or repeated tests and duplicative office visits. In an ACO, doctors and hospitals will no longer be rewarded for the volume of care provided; instead, they will be paid based on their ability to provide preventive care and keep people healthy. For example, if the ACO can work proactively with a heart failure patient to manage medications and recommend lifestyle changes that improve their condition, they can prevent serious complications that require expensive surgeries and long hospital stays. The savings generated from these care improvements can then be shared by the ACO and the payer as an incentive to promote value rather than volume. When doctors, hospitals, nurses and other care providers efficiently deliver the right care, in the right setting, people benefit and overall costs will be reduced, and these efficiencies will continue overtime."

Wes Champion
Senior Vice President of Premier Consulting Solutions
Premier healthcare alliance
Charlotte, N.C.

Potentially, yes, but only if payment methodologies change in an aligned fashion. What is most important is that we achieve accountable care – i.e. better coordinated care, more transparent to the consumer, using evidence-based measures to achieve better outcomes, greater patient satisfaction and improved cost-efficiency. ACOs are provider-based organizations comprised of multiple providers with a level of clinical integration sufficient to deliver accountable care. But ACOs cannot achieve these goals alone. Payment systems also will need to move away from fee-for-service to payment arrangements that incentivize greater provider collaboration. And ACOs will need strong, effective and collaborative relationships with both private and public purchasers and payers to be successful. Some organizations that combine provider and payer elements today, such as Kaiser, Geisinger and Intermountain, are well-positioned to align payment and delivery change, at least for lives they cover directly. But such alignment will be necessary on a much broader scale to achieve a meaningful impact on the cost curve on a national basis. The concepts underlying shared savings, bundled fees and global or capitated payments are promising in this regard and being explored in various pilot programs and demonstrations. The PPACA, particularly through Sections 3021, 3022 and 3023, will drive greater testing of these concepts at the federal level. Determining best practices in accountable care – both in payment methodology and delivery system organization and operations – and expanding such practices on a national basis will take time. But the promise is there.

Doug Hastings
Chair of the Board of Directors
Epstein, Becker & Green, P.C.
Washington, D.C.

*T*hought Leader's *C*orner…*continued*

Can Accountable Care Organizations have a meaningful impact on the cost-curve? ACOs have the potential to develop structures and processes to enable better cost control, but external economic forces must align to get results. A critical mass of payers with directionally consistent incentives will be needed. CMS fee for service is a good start but not enough; we need Medicaid and the private sector to come along also. Another key issue is that in every case, measurement of ACO performance relies on the existence of a cost target andhow this target gets set is critical. Performance against this target determines shares savings, future fee schedules and/or dollars left in the ACO's budget. CMS is contemplating setting targets by using a retrospective analysis of the ACO's own performance on risk adjusted per member cost increase relative to national increases. This imbeds a relative cost curve change into the formula, but is tough on ACOs as they won't have any idea of how they are doing until long after the fact. In the private sector, these targets are negotiated; meaning larger systems with more clout can and will demand higher targets. I strongly believe that we must bring consumers into this picture. If consumer premium or benefit cost sharing was based on each ACO's target, then ACOs would need to keep their targets competitive to attract and retain market share, negating the incentive to keep pushing targets higher, and rewarding the best performers with patient market share.

Ann Robinow
President
Robinow Health Care Consulting
Minneapolis, MN

Accountable Care Organizations are one of America's best hopes for reducing healthcare costs without rationing, but only if they receive the right kind of support to dramatically change the way healthcare is delivered. The single most critical type of support that ACOs need is meaningful payment reform. It is widely recognized that the structure of current healthcare payment systems frequently prevents or penalizes efforts to improve the quality of health care and control healthcare costs. For example, many studies have shown that the rate at which people with chronic diseases are admitted to the hospital can be dramatically reduced by having nurses make home visits, by encouraging patients to call their doctor early, and by improving access to primary care practices on evenings and weekends. But current fee for service payment systems don't pay for nurse care managers and they don't pay doctors to talk to patients on the phone. The obvious solution is to pay for those things, in return for accountability by PCPs to keep their patients well and avoid hospitalizations. Another example is that tens of thousands of people still get infections in hospitals that cost millions of dollars to treat, but under current payment systems, hospitals lose money – a lot of money – when they prevent those infections. Again, the solution is obvious – pay for care that has a warranty, the same way we pay for products and services in every other industry. Unfortunately, the most commonly discussed payment change for ACOs is "shared savings," which is nothing more than a new form of pay-for-performance (P4P). Shared savings makes no change in the flawed fee-for-service system; it still pays more for more services, it still pays more for correcting errors and complications than for preventing them, and it still fails to pay for many services that could prevent the need for more expensive care. Moreover, it provides no upfront resources to help physician practices invest in the care changes that could save money overall. In other words, it's not genuine payment reform. The Patient Protection and Affordable Care Act authorizes CMS to use payment methods other than shared savings to support ACOs, and hopefully CMS will do so. Commercial payers and state Medicaid programs also need to move to more value-based payment systems. With genuine payment reform from all payers, ACOs could significantly reduce healthcare costs without rationing.

Harold D. Miller
Executive Director, Center for Healthcare Quality and Payment Reform,
President & CEO, Network for Regional Healthcare Improvement,
New York, NY.

Building the Foundation …. *continued*

Completion of the Exploration phase signals readiness to begin transition to the second phase, Planning. As Levett, Hannah and Roberts[2] note, there is an intermediate step between Exploration and Planning – when the partner-collaborators are able to make a commitment to assign resources to formation of the ACO and the accompanying cultural transformation. Once all of the enumerated components of the Exploration stage have been fulfilled, the participants should have the information (and confidence) to affirm their investment in moving forward. The Accountable Care Organization represents a capable model for improving the quality of healthcare, controlling costs, and assuming accountability for outcomes. One of the challenges to forming an ACO, however, is integrating multiple clinical and nonclinical environments into a unified, cohesive culture focused on achievement of measurable goals. A four-phase process of cultural transformation has been proposed, outlining a deliberate, intentional approach to managing the change. The authors assert that the initial, foundational Exploration phase – self-assessment and analysis, thoughtful selection of partners, and careful examination of opportunities and issues -- is essential to building an organizational and cultural framework upon which the ACO can grow. In fact, we contend the very success of the ACO hinges on it.

Continued on page 11

INDUSTRY NEWS

PREMIER

Premier's Healthcare Alliance Accountable Care Organization Readiness Collaborative Joined By Over 40 Healthcare Systems

Over 40 leading health systems are now participating in the Premier healthcare alliance's Accountable Care Organization (ACO) Readiness Collaborative. The participating health systems will evolve the organization by working together with the skills, team and operational capabilities necessary to become effective ACOs capable of lowering costs by improving care coordination, efficiency, quality and patient satisfaction.

Accountable care organizations are formed when healthcare providers come together as a group and accept accountability for a defined patient population's care. Their purpose is to keep patients healthy and out of intensive care settings. ACOs will also strive to reform payment delivery by rewarding providers who supply better care that leads to more cost-effective outcomes.

"Together, health systems in the ACO Readiness Collaborative will build the knowledge and expertise needed to transform today's system from one that treats illness, to one that delivers health and wellness," said Premier president and CEO Susan DeVore. "In moving forward this way, these health systems are truly implementing the goals of healthcare reform – improved healthcare outcomes at the most cost-effective price for patients and taxpayers."

AMGA

AMGA Collaborative on the Development of Accountable Care Organizations to feature 19 Health Care Systems

19 top-tier medical organizations, representing 10,500 providers and over 5 million patients will now be involved in the ACO Development Collaborative which is scheduled to have its first meeting along with the AMGA National Summit on Accountable Care Organizations (ACOs).

Member organizations will be assisted by the AMGA's ACO Development Collaborative to acquire and improve the necessary characteristics to become an ACO. The participating members include: ABQ Health Partners, Albuquerque, NM; Advocate Physician Partners, Mount Prospect, IL; Alegent Health Clinic, Omaha, NE; Arch Health Partners, Poway, CA; Crystal Run Healthcare LLP, Middletown, NY; District Medical Group, Phoenix, AZ; Esse Health, St. Louis, MO; Harbin Clinic, Rome, GA; Holzer Clinic, Gallipolis, OH; Montefiore Medical Center, Bronx, NY; New Lexington Clinic, PSC, Lexington, KY; Physicians of Southwest Washington, Seattle, WA; The Polyclinic, Seattle, WA; The Portland Clinic, LLP, Portland, OR; Portland IPA, Portland, OR; Vanderbilt Medical Group, Nashville, TN; Walla Walla Clinic, Walla Walla, WA; Weill Cornell Physician Organization, New York, NY; and Wilmington Health, Wilmington, NC

EXETER HOSPITAL

Exeter Health Resources Gets Involved in the First Statewide ACO Pilot Program in New Hampshire

Exeter Health Resources is now participating in the New Hampshire Citizens Health Initiative's Accountable Care Organization (ACO) Pilot Program in a bid to pursue its mission to improve the health of New Hampshire's Seacoast communities. Kevin Callahan, president and CEO of Exeter Health Resources, said that "The ACO initiative presents an opportunity for Exeter Health Resources to continue in its efforts to reinvent health care delivery in a manner that improves access, efficiency and quality through enhanced collaboration in the delivering of care to our patients".

THE CHARTIS GROUP

Report For Hospitals to Prepare forACOEnvironment

The Chartis Group has published "Improving Performance and Building Capabilities During Turbulent Times" The Chartis Group highlight a Market Evolution Framework that presents the importance of cost management for hospitals and health systems, and emphasizes three other key initiatives that must be addressed: care management, network management, and population health management. The report describes how providers in different local markets can be affected at different rates by the various impending market pressures. It recommends that hospitals and health systems prioritize and carefully sequence their focus on all four management areas in order to successfully operate in a future environment that places a greater degree of financial risk on providers and pushes them to organize and effectively function within an accountable care environment.

Building the Foundation …. *continued*

1. Recommended articles include: Shortell, S.M., Casalino, L.P. 2008. Health Care Reform Requires Accountable Care Systems. *JAMA*, 300(1): 95-97; Miller, H.D. 2009. How to Create Accountable Care Organizations. Pittsburgh (PA): Center for Healthcare Quality and Payment Reform; Fisher, E.S., Staiger, D.O., Bynum, J.P.W., Gottlieb, D.J. 2007. Creating Accountable Care Organizations: The Extended Hospital Medical Staff. *Health Affairs*, 26(1): W44-W57; Taylor, M.. 2010. The ABCs of ACOs. *Hospitals and Health* Networks, 84(5): 26-38; and Bertko, J. 2009. Delivery System Reform: Developing Accountable Care Organizations. www.academyhealth.org/files/SQII/Bertko.pdf
2. Levett, J.M., Hannah, J., Roberts, P.W. 2010. Managing to Change: A Model for Cultural Transformation for the Accountable Care Organization. *Group Practice Journal*, 59(6): 8-13.
3. Wagner, E.H. 1998. Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness? *Effective Clinical Practice*. 1(1): 2-4; and Nichols, L.M., Weinberg. M., Barnes, J. 2009. Grand Junction, CO: A Health Community That Works. www.Newamerica.net.
4. See discussion of complex adaptive systems in Levett, J.M., Roberts. P.W. The Accountable Care System: A Business Model for Population Health Management. Accepted for publication in *MGMA Connexion* **,** Fall 2010.
5. Kotter, J. P. 2008. *A Sense of Urgency*. Boston (MA): Harvard Business School Publishing.

INDUSTRY NEWS

Three Tips For the Transfer of Financial Risk In Accountable Care

Hospital Review reports that the shift from fee-for-service model to accountable care in the healthcare industry marks a fundamental difference in who manages the risk. As we get closer to accountable care, risk will gradually transfer from the health insurers over to the health providers. Providers will need to understand the risks associated with the populations they manage and appropriate many of the tools and processes currently employed by health insurers. Here are three tips from Nathan Gunn, the chief science officer for Verisk Health, that could help hospitals and providers undertake this shift.

1. Understand the risk in your population.

Dr. Gunn says that the most important element to the success of an ACO is its ability to understand the risk of a population, "ACOs are going to have to develop skill sets around analytics that once were solely the providence of health plans," he says. The provider needs to understand the risk of a population and the cost associated with that risk in order to make sure that it receives fair pricing for managing that population's care. "If a population is twenty percent sicker than expected, the provider needs to make sure it's getting 20 percent more for that care," says Dr. Gunn.

2. Thoughtfully allocate resources.

As well as assessing risk, analytics can aid providers in identifying where their resources should be allocated to get the most return on their investment. "Predictive models can show providers who in a population they should focus their time and effort on," says Dr. Gunn. "Identifying the riskiest one percent who are most likely to require expensive care allows providers to focus more disease and case management efforts toward these patients and hopefully reduce their costs."

Following the identification of patients most likely to fall ill, the next move is searching for holes in care, a process which necessitates increased analysis of EMR data and claims on an individual patient level. In doing so one can highlight gaps in care that might well have made a contribution towards increased risk. This very process of identification is instrumental in filling these gaps to prevent the recurrence of similar or indeed the same problems in the future.

3. Profile internal providers.

Providers have been profiled by insurers for quite a long time as a way to steer patients in the direction of those which provide better cost effectiveness and higher quality care. Unfortunately, this process of provider profiling has thus far failed at moving any sizable portion of healthcare consumers in the direction of better quality providers. However, while bearing the past in mind, there is no reason by ACOs with numerous providers ought not to continue and improve upon the practice of profiling.

continued…

Three Tips For the Transfer… *continued*

"A medical director of the ACO should understand which of the clinics or hospitals in the ACO has the best quality and efficiency," claims Dr. Grunn. According to Dr. Grunn ACOs can succeed at identifying and implementing best practices across their entire networks by aggressively zeroing in on high level performers and rewarding them for their performance.

California Provider Groups Seek Out Accountable Care Organizations to Improve Care Coordination after the Passage of Health Reform

Californian provider groups, including physician groups, independent practice associations, hospitals and medical foundations, have begun to shape their own role in the upcoming shift to accountable care organizations (ACOs), reports HealthLeaders-InterStudy, a leading provider of managed care market intelligence.

Because of health reform, hospitals will now be held accountable for the quality of care in their community and will this be interested in the possibilities that ACOs could offer to help improve the coordination of care for their patients and streamline the reimbursement processes. The anticipated federal use of ACOs for fee-for-service Medicare is stirring high interest among provider groups and hospitals, leading to partnership discussions, according to the recent California Health Plan Analysis. This means that ACO could involve a variety of structural relationships between physicians, hospitals and health plans — a movement that would surely continue consolidation in the provider community.

"In preparation for the ACO pilot projects, some hospitals are looking to establish medical foundations that will give them the legal authority to work more closely with physician groups to coordinate care," says Chris Lewis, senior market analyst with HealthLeaders-InterStudy. "The ACO development for fee-for-service Medicare means closer care management of many more beneficiaries. Hospitals that have arrangements with physicians that align incentives and allow for coordination of care are well positioned to form an ACO."

Subscribers' Corner

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Catching Up With …

David L. Bronson, MD, President of Cleveland Clinic Regional Hospitals, Cleveland Clinic, Chair, Board of Directors, American Medical Group Association (AMGA), Cleveland, OH.

Dr. David Bronson has served on Cleveland Clinic's Board of Governors, Board of Trustees and the Executive Management Team. He also is Professor of Medicine at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University. He is a member of the Board of Regents of the American College of Physicians and a member of the Board of Commissioners of the Joint Commission and also serves as Chairman, Board of Directors of the American Medical Group Association. He joined Cleveland Clinic in 1992 and led the Clinic's multi-site regional practices, including operations in Canada, from 1995-2008. Dr. Bronson received his medical degree from the University of Vermont and completed residencies in internal medicine at the University of Wisconsin and the University of Vermont, where he was chief resident.

David Bronson, MD

* Castello Award, University of Wisconsin, 1973-1974
* Teacher of the Year, University of Vermont Department of Medicine, 1981, 1982, 1985
* American College of Physicians
  - o Fellow, 1987-Present
  - o Chair, Board of Governors, 2007-2008
  - o Board of Regents, 2006-2009
  - o Executive Committee, Board of Regents, 2006-2009
* American Medical Group Association, Board of Directors, 2003-2009, Treasurer, 2008
* American Medical Association, House of Delegates, 2007-2008

Accountable Care News: *Not long ago, the American Medical Group Association (AMGA), which you chair, released its "Accountable Care Organization Principles" as a guide to the development of ACOs. How do you see the AMGA's role going forward as CMS begins to define and regulate the growth of ACOs?*

David Bronson, MD: The AMGA medical groups have more experience doing things like ACOs than any other organization and we believe that leaders from the AMGA can play an important role in helping advise CMS's development of regulations that will really define the success or failure of this approach.

Accountable Care News: *Given the attention the Medicare Shared Savings Program is receiving, how much if any focus are you seeing on ACO development or activity to serve other patient populations at this point?*

David Bronson, MD: Frankly I'm not seeing very much, I probably should check with our national office to see if they're seeing any activity but we're not seeing much in this market at all.

Accountable Care News: *Do you have any concerns that physicians in an accountable care organization model might have their own treatment decisions second-guessed by the health insurer absent a global payment arrangement?*

David Bronson, MD: One of the major concerns confronting us is that we don't turn accountable care into a repeat of the 1990s managed care and HMO models. If we do that then we're going to repeat history and all of the challenges that we had before. The regulations which define what exactly accountable care organizations are will be incredibly important to help the endeavor be successful. Ideally, physicians and hospitals will be rewarded for their work and effort to improve care overall. Thus the regulations are very important and that is one of the reasons we believe AMGA is best positioned to help guide this in a way that can be successful.

Accountable Care News: *In addition to a regular CEO, Cleveland Clinic also has a different kind of CEO, a Chief Experience Officer, who looks after patient-centered care. What brought about the creation of this position and what duties are associated with it?*

David Bronson, MD: This is a unique endeavor for the Cleveland Clinic that we first started a few years ago. We recognize in this organization that what our patients think about their experiences is as important as what actually happens in terms of outcomes. We have patients who made it out of life-threatening illnesses against the odds and sometimes they won't have been treated as well as they should have been and we don't want to see that happen. We wanted to elevate the whole concept of patient satisfaction to a higher level in the organization. Dr. Cosgrove, who is our CEO, said, "I want someone who cares about people a lot, a physician leader who will report directly to me on this initiative". Since we started it a few years ago patient experience has become a factor to provider payment. I think we're a step ahead of the game on this but it's going to be an area of emphasis for most medical centers. The duties of the chief experience officer are: Number1: Help evaluate measurement; Number 2: Help and plan departmental institutional programs across our enterprise; Number 3: Help plan an orientation program for our employees to experience what we're doing; Number 4: Most importantly, keeping a spotlight on this for us all by having a team experience officer who reports to the CEO and sets up a lot of meeting agendas.

Accountable Care News: *Finally, tell us something about yourself that few people know.*

David Bronson, MD: Few people would know that I'm the oldest of seven children, I'm the first doctor in my family, I grew up in Maine and I love my work!